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Mercy Services West Liberty  
Patient Assessment

Patient Name Mills, Smack Allergies PCN D.O.B. 6/29/65

Date of Service:	<u>1-31-06</u>	Office Visit:	<u>10</u>	Phone Call:	
Ht.:	Wt: <u>270</u>	Temp:	BP: <u>126</u>	HR: <u>90</u>	RR:
Current Meds:	<u>asa for pain 80</u> <u>Stepped back from switch + fell / sprain</u> <u>Sprained 11/2/05</u> <u>xray neg</u>				
Chief Complaint:	<u>work related ankle sprain to R ankle in Nov 05.</u> <u>was sent to work @ low activity + thought things were OK.</u> <u>but now can't be pain free + swollen.</u> <u>Had x-rays @ time of injury. Was a brace + no exercise</u>				
Nurses Signature:	<u>[Signature]</u> (cant squat)				

was seen by Dr Johns @ mercy Occupational Health  
was released by Dr Johns to RTW.

cant do anything  
(standing)

Date of Service:	<u>2/10/06</u>	Office Visit:	<u>X</u>	Phone Call:	
Ht.:	Wt: <u>271</u>	Temp:	BP: <u>130</u>	HR: <u>80</u>	RR: <u>16</u>
Current Meds:	<u>Ø</u> <u>19 cmt</u> <u>Physical Therapy → PT</u> <u>we met 2/1/06 - 2/10/06</u>				
Chief Complaint:	<u>FLU R ankle sprain - needs FMLA paperwork</u> <u>done</u>				
Nurses Signature:	<u>[Signature]</u>				

Date of Service:	<u>2.24.06</u>	Office Visit:	<u>10</u>	Phone Call:	
Ht.:	Wt: <u>274</u>	Temp:	BP: <u>120</u>	HR: <u>80</u>	RR:
Current Meds:	<u>asa</u> <u>74</u>				
Chief Complaint:	<u>Fell @ home last wk. + twisted R ankle -</u> <u>stopped on the ice</u> <u>has resumed brace - still is swelling</u> <u>Reinforced to fall on ice last time</u>				
Nurses Signature:	<u>[Signature]</u> 2/24/06				

3/15 to see Dr. [unclear] on 3/16 @ 1:15

We note [unclear] - 7/1/06

F) If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

Weekly office visits to evaluate rehab. progress

- If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recover if any:

2-3 treatments weekly by Physical Therapy

- If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

Physical Therapy - Exercises, Electrostimulation & other modalities as indicated

- If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

PT, NSAIDS

G) If medical leave is required for the employee's absence of work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

Yes, at the time

- If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)?

If yes, please list the essential functions the employee is unable to perform:

If neither of the above in G, is it necessary for the employee to be absent from work for treatment?

H) If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

- If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?
- If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need?

Signature of Health Care Provider:

Dianna Sprague PA-C

Date:

2/10/04

Complete Address:

1401 Creech St., West Liberty, IA 52776

Telephone No. (319) 627-2131

Type of Practice:

family practice

Dianna Sprague PA-C

(continued)

2-10-06 2

**CERTIFICATE OF HEALTH CARE PROVIDER**  
(For Family and Medical Leave and/or Short Term Disability Benefits)

The Certification of Health Care Provider is to be completed by the employee and health care provider verifying the serious health condition of the employee or employee's immediate family member for whom the employee wishes to provide care. If there are any questions about this form, contact the Human Resources Department at 319-298-5402. The completed form should be faxed to HR at 319-298-5458. Or mail to: Iowa Interstate Railroad at 5900 6<sup>th</sup> St SW, Cedar Rapids, IA 52404.

**To Be Completed by Employee**

Employee Name Michael Smock Emp No. 662 SS# 484-84-2036

Address 2141 Hwy #6 Atalissa Iowa 52220

Home Phone 563-644-2230 Dept Tice Occupation conductor

I am requesting a leave of absence: ☒ for my own serious health condition  
☐ to care for a family member

If the leave is to care for a family member, state the care you will provide and an estimate period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature Michael Smock Date 2-10-06

**To Be Completed by Health Care Provider**

Employee Name Michael Smock Patient (if different from employee) \_\_\_\_\_

A) The Attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

\_\_\_\_ (1) ☒ (2) \_\_\_\_ (3) \_\_\_\_ (4) \_\_\_\_ (5) \_\_\_\_ (6) or None of the above \_\_\_\_

B) Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

Right Ankle sprain with persistent pain, swelling and instability that has not responded to conservative treatment.

C) State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's incapacity<sup>2</sup> if different:

November 2, 2005

D) Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item G below)? yes If yes, give the probable duration:

Approximately 2/1/06 - 2/24/06

E) If the condition is a **chronic condition** (condition B) or pregnancy, state whether the patient is presently incapacity<sup>2</sup> and the likely duration and frequency of episodes of incapacity<sup>2</sup>:

- 1) Here and elsewhere on this form, the information sought relates ONLY to the condition for which the employee is taking FMLA leave.  
2) "Incapacity" for purposes of FMLA, is defined to meaning ability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

2/27/07 Michael Smock DOB: 6/29/65

P: Work release, elbow pain.

D. Sprague PA-C/L. Hanna MD/lmd

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S: Mike is here for a note to release him to return to his job at the railroad after a long absence due to his recurrent right ankle pain and instability which was always aggravated by any kind of activity which encouraged some instability. His ankle has remained stable over the past several months and at this point he's ready to return to work and see how he does. He would like me to take a look at his right elbow. He has some pain out over the lateral epicondyle. He's had no weakness. No particular trauma has contributed to this. We also talked about his asthma. If he can afford the Advair, 1 puff in the morning works wonderful and he rarely reaches for his Albuterol. We have tried our best to keep him in samples if we have them.

O: Weight 277. BP 110/72. Exam of his arms notes he has classic tenderness over the right lateral epicondyle. Joint has normal ROM. Hand grips are equal bilaterally. Inspection of both feet and ankles notes that the lateral malleolus on the right ankle seems a little bit more prominent and he has just some very mild tenderness inferior and a little anterior to the lateral ankle to palpation. ROM seems normal. Perhaps a little bit of laxity with inversion. Distal pulses are intact. He has good capillary refill. There's no swelling or bruising.

A: 1. Hx of right ankle pain and sprain. I think he has some residual instability but unfortunately we haven't been able to do a MRI to double check underlying structures.  
2. Right lateral epicondylitis.

M. Smock - 2

3. Stable mild asthma.

P: Switched him over to a trial of Azmacort from samples and recommend 2 puffs 2 to 3 times a day along with his Albuterol p.r.n. Work note was written for him for release to return to work without restrictions starting today. For the elbow recommend a tennis elbow splint which he can buy locally and we'll see him back periodically and other visits p.r.n.

Smock, Michael

BD: 06/29/65

CHART # 002079.0

DOS: 11/05/07

CC: Asthma.

S: Michael is here today for a refill on his Advair and an exacerbation of his underlying asthma. He has been using his albuterol inhaler five or six times a day and still feeling rather tight and wheezy and like he cannot breathe. He has previously been on Advair in the past with great success, although this has been a very expensive medication for him to afford. I have tried him on Azmacort in the past and this was not helpful. He has actually not needed any steroids that I am aware of for quite some time. We tried Singulair. He has tried numerous antihistamines to see if management of any underlying allergies would be helpful and none of these have also been helpful.

O: His weight is 282 pounds. BP is 122/53 with a large cuff. He is a heavyset tall gentleman in no acute distress and actually looks like he is breathing comfortably. HEENT looks not inflamed. Neck is supple without adenopathy. His lungs actually have good excursion. I did not hear a single wheeze. No rhonchi.

A: Chronic asthma. I do believe he probably has an exacerbation of this, but I think it's more just not well managed rather than a significant acute problem.

P: I gave him samples of both the Symbicort 160/4.5 mg to use two puffs b.i.d. and also we had Advair Diskus 250/50 mg, three of these. He will give the Symbicort a try. It is not less expensive, but it is something that we have more samples available and also he may find it just as useful. I recommend he use two puffs of the Symbicort twice a day or the Advair one puff twice a day and if he does not find his albuterol use has dropped back to just minimal, he is to follow-up.

Dianna L. Sprague, PA-C/Dona! Gordon MD

DS/ncgs/DPK/DLS11045/pdc/R: 11/06/07 T: 11/07/07

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